



Doctor Perspectives

Hall, Kistler & Company LLP

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Specializing in Financial and Management Services for Health Care Organizations

2008 CPT CODING CHANGES

Although we are almost midway through the year, we are still encountering practices that have not updated their coding policies to reflect the changes made for 2008. With increasing instances of payers placing providers on pre-payment review, it is very important for every practice, and outpatient or inpatient facilities (all specialties) to stay up to date with coding guidelines. Below you will find a summary of the updates made to the E/M Section and Modifiers in the AMA's Current Procedural Terminology or CPT for 2008.

Evaluation and Management Codes:

Subsequent Inpatient Neonatal

Critical Care - Birth weight guidelines for this code, 99296, were added to clarify when to use this code or choose a code from the Continuing Intensive Care section or Subsequent Hospital Care section.

Nursing Facility Care - For codes 99304-99306, 99307-99310, and 99318 the CPT was updated with typical number of minutes spent on each of these codes. This provides a better guideline to choose the appropriate nursing facility code.

Case Management Services - Codes 99361, and 99362 were deleted. New codes 99366 and 99367 were added to more clearly define Medical Team Conferences that are either Face-to-Face with the patient and/or family, or Medical Team Conferences without

contact with the patient or family.

Also, code 99368 was added to report the participation of a non-physician provider in the Medical Team Conference. Please keep in mind that in order to use these codes, the conference must last over 30 minutes.

Behavior Change Interventions,

Individual - New codes for smoking and tobacco use cessation counseling, 99406 and 99407, and Alcohol and/or substance abuse screening and intervention, 99408 and 99409, were added. These codes can be selected according to the time spent in counseling.

Non-Face-to-Face Physician Ser-

vices - Telephone Call codes 99371-99373 were deleted in order to establish new more detailed guidelines for these services.

Telephone Services - Codes 99441-99443 were added to report telephone services provided to established patients and are to be chosen according to time spent in medical discussion with the patient/parent/guardian. You must be careful when using these codes, as there are several criteria that have to be met. The service must not originate from any E/M service provided to the patient within the last 7 days, and it must not lead to an E/M service or procedure within 24 hours, or the next soonest available appointment. (Use codes 98966-98968 for non-physician practitioners rendering these services).

On-line Services - Code 99444 was added to report an online evaluation and management service provided to an established patient. Again, the online evaluation cannot originate from any related E/M service provided within the previous 7 days. Please remember that these services "must involve permanent storage of the encounter", either in their EMR record or in hardcopy in their medical chart. (Use code 98969 for non-physician practitioners rendering this service).

Other Evaluation and Management

Services - Code 99477 was added in order to report the initial hospital care of a neonate, 28 days old or less, who requires intensive observation, frequent interventions, and other intensive care services.



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2008 CPT CODING CHANGES

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Modifiers:

Modifier 22 - Unusual Procedural Services - The name of this modifier has been changed from “Unusual Procedural Services” to “Increased Procedural Services”. This modifier may be reported when the work that is required to provide a service is substantially greater than typically required. Your documentation must support the additional work as well as clearly define the reason for the additional work (i.e. severity of patient’s condition, time, intensity). Please remember that this modifier should never be used with an E/M code.

Modifier 25 - Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service - Only a slight change in wording in the description of this modifier, please review before using.

Modifier 51 - Multiple Procedures - New language was added to the description of this modifier to exclude physical medicine and rehabilitation services, and provision of vaccines from being reported as multiple procedures.

Modifier 58 - Staged or Related Procedure or Service by the Same Physician During the Postoperative Period - Only a slight change in wording in the description of this modifier, please review before using.

Modifier 59 - Distinct Procedural Services - The reference to the physician was deleted so that the modifier can be used by any qualified health care professional. Please remember that this modifier must be used by the same individual who performed the other procedure, and may only be used on non-evaluation and management services.

Modifier 78 - Return to Operating Room for a Related Procedure During the Postoperative Period - The name of this modifier has been changed to “Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period”. This change provides clarification that the subsequent procedure was in fact unplanned, and that the same physician performed it.

It is not too late to become familiar with the CPT changes affecting your practice this year. In addition to the above, there were also many changes made to the following sections of the 2008 CPT:

- | | | | |
|---------------------|----------------------|------------------------|---------------------------|
| •Anesthesia | •Digestive System | •Female Genital | •Pathology and Laboratory |
| •Musculoskeletal | •Urinary System | •Eye and Ocular Adnexa | •Medicine Section |
| •Respiratory System | •Reproductive System | •Radiology | |

The changes were effective January 1, 2008, so it is important to check that your practice has the proper coding procedures in place. Below is a list of ways your office can make sure that it is ready for a new year of coding.

Checklist for making the transition:

- Make sure you do your research and find all of the changes that will affect your practice. Only the additions and deletions are listed above, there are also changes in descriptions. Also, it is a good idea to become familiar with all of the new changes even if they do not directly affect your practice.
- It is best to order the Professional Edition CPT book each year. Having a coding book from 2004 will not help you or your staff when faced with coding questions. The Professional Edition of the CPT provides more comprehensive information, and does not cost substantially more than the non-professional edition.
- Add or delete the appropriate code changes to your charge master or superbill, if not, you could be making mistakes repeatedly without knowing it.
- Make sure that all of the appropriate providers and staff are trained to know and understand the changes and how or if they will affect your coding and documentation procedures.
- Become familiar with the changes in the ICD-9 and HCPCS manuals as well.



LEASE VS. PURCHASE DILEMMA (HOW TO WIN IN MEDICAL REAL ESTATE)



With the interest rates continuing to remain steady along with ongoing uncertainty in the stock market, many physicians are electing to diversify their investments. One of the most viable investment opportunities is the office space used by a medical practice. From office condominiums to freestanding office buildings, there are real estate opportunities in the Metro DC medical market to consider. However there are both pros and cons to consider based on your type of practice and the investment strategies of the practice principals.

The major advantage of a *purchase option* is that it gives physicians the ability to sell their practice but maintain residual real estate income. It is important when buying real estate to be used by your practice that you set that investment up in a separate real estate partnership. Buying real estate provides the physician(s) a secure place to practice for years to come, as well as a downstream of retirement income in the future.

Accordingly, the *leasing option* provides flexibility in medical practice location and size with a much lower initial cash outlay. Depending on the actual business situation, a physician may want multiple locations to practice in several days a week in order to attract a diverse patient population. Leasing allows physicians to do this with possibly less expense.

Consider all the factors before you buy or sign your next lease or lease re-

newal. You should start by creating a list of the pros and cons and then do a side-by-side lease vs. purchase financial analysis on the specific opportunities identified.

Weigh the Lease aspects:

Lease Positives

- Lower cash requirements
- More maneuverability & versatility
- Easier to relocate

Lease Negatives

- No equity or wealth building
- Possible increasing rents
- Could be forced to relocate



Then weigh the Purchase aspects:

Purchase Positives

- Building equity
- Control occupancy cost
- Tax savings
- Cannot be forced to move

Purchase Negatives

- Cash investment usually required
- Some management responsibilities
- Must sell or lease space to move practice



When conducting the financial comparison, consider the impact on the medical practice.

- Will locating your practice in a large medical building bring more referrals or increase patient census?
- Will the free parking and signage possible with ownership attract more patients?
- How might each possible location increase or decrease the practice's patient volume?

With a defined time period in mind on your analysis, do the math. First compare any moving costs as well as the occupancy costs of each identified opportunity over a 10-year period. After that conduct a side-by-side financial comparison of the lease versus purchased space.

On the purchase options, compute the negatives like the lost benefits of the cash outlay and any management cost or time lost. Once this is completed then compute the positive aspects of appreciation, loan principal reduction and tax benefits. Your lease vs. purchase decision will be much easier once the bottom line of each choice is clearly denoted.



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PRACTICE SCHEDULING: CHAOS VERSUS COHESION

A good daily schedule can make all the difference in your practice – to the staff, to the providers and to your patients. It can mean the difference between a stressful, unenjoyable day versus a smooth, pleasant one. Scheduling is the key to your patient's access to the medical care they need and this makes it one of, if not the most important factor, in how you run your practice.

Scheduling for a medical practice is an "Art Form". Whether it's an urgent call from a patient, who has been feeling badly for many days on a day when your schedule is already overbooked, or a late patient or a no-show on a slow day when you could have booked several follow-up exams. How does your practice deal with all of this unpredictability?

Problems with your practice schedule can reduce the quality of care you give to your patients and in a problematic scheduling environment, your receptionists will spend a lot of their time on the phone with irate patients trying to explain why your practice cannot meet their needs. Poor appointment scheduling also leads to a higher no-show rate, which inevitably leads to reduced practice profitability.

The goal of your schedule should be that your practice will and can see patients as soon as possible for urgent visits and within a week – no more than two for non-emergent issues.

Another goal should be to see your patients in a timely manner to avoid having them go to an urgent care center for non-emergencies or the local emergency room because you could not "fit them in" on your schedule.

The key is to find a balance between the services you can provide and the

needs of your patients. Here are a few ideas you might explore to make your office schedule more compatible for your patients and your staff:

Improve your Efficiency. This is a great place to start, not only will increasing efficiency improve the way your practice handles its workload; it should improve profitability as well. Make sure your entire staff is working as efficiently as possible. Training in time management, teamwork and multi-tasking may be a good investment for your staff.

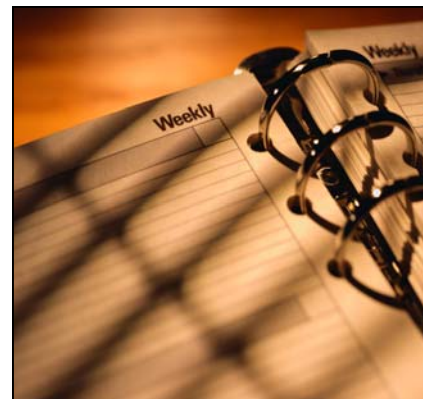
Analyze Appointment Availability.

- Study your schedule to identify how long a patient has to wait for the next available new or return patient appointment.
- Analyze your no-show rate.
- Measuring your new patient to total patient ratios can be important as well, especially for physicians who perform procedures.
- Identify trends in patient needs, requests and schedules.

After you gather this information, it is important that you make the proper allowances to your scheduling template as needed based on your findings.

Increase your Practice's Availability. Adding a few more hours to your day or week can provide extra, needed appointment time for your patients. Consider adding "walk-in" hours for sick patients in the morning and then again at the end of the day during flu/cold season outside your normal business hours. Definitely block some time each day for urgent/same day patient visits. For those of you whose time is stretched too thin as it is, you may want to look at hiring another doctor, a Nurse Practitioner or a Physician's Assistant.

Same Day Appointments all day, every day. Some practices have



moved to a same day appointment schedule all together. Phones open at 8:00 am every morning and patients are scheduled for appointments that day. Once the schedule is full you start triaging and/or scheduling patients for early appointments the next morning as soon as the office opens while the phone operators are scheduling same day appointments for that day.

Practices who have moved to this say it is actually easier, the patients love it, and the profitability of the practice has increased dramatically. You might want to poll your patients in advance to see if this method would be accepted and welcomed.

You could also try this method two days per week (Mondays and Fridays) to see how it goes before you move to this scheduling method full time.

Unfortunately, managing a medical practice is much more difficult than most other businesses. Your patients require more than the typical 9 to 5 service hours. Your scheduling template can either cause chaos or allow for great patient service. Any steps that you take to improve your accessibility, will improve your patients overall satisfaction with your practice. Please give us a call if you would like us to help you perform an analysis to see if your practice would benefit from some major changes to your scheduling template.



2008 OIG WORKPLAN: MAKE SURE YOUR PRACTICE IS IN COMPLIANCE

It is a good idea to review the OIG workplan each year as it is released to ensure that your practice is in compliance with regulations and is aware of any hot areas of investigation. This year, the 2008 OIG workplan contains some new targets as well as continued areas of investigation. Since this is our first newsletter of the year, we have provided a summary of the areas of investigation that will directly affect Physicians and other healthcare providers.

Incident to Services - The OIG will investigate whether physicians are billing for “incident to” services in compliance with the rules. Also, it will look into the qualifications and appropriateness of the staff that perform these services.

Business Relationships and Use of MRI - Following the concerns reflected in the 2008 physician fee schedule and the new Stark regulations, the OIG is studying the arrangements under which physicians are paid under Medicare for diagnostic services. Specifically, the OIG will “pay particular attention to financial relationships among the parties involved in providing services and identify whether such relationships are associated with high use of services.” It appears that the OIG’s main concern is improper referrals for these services.

Place of Service Errors - The OIG will review physicians’ place of service codes for services performed in ASC’s and hospital outpatient departments. Physicians usually receive reduced reimbursement for procedures performed in ASCs and hospitals since they are paid under the facility rates. The OIG wants to determine if physicians are miscoding claims to capture the higher level of reimbursement for services performed in these settings.

E&M Services During the Global Surgery Period - This OIG study will track industry trends in how E&M services are provided during the global surgery period, and whether physicians are complying with the global surgery billing rules.

Pain Management Services - Because of the significant rise in pain management payments, the OIG will review the appropriateness of Medicare payments for interventional pain management. They will also be reviewing physician oversight of the performance of pain management procedures.

Reassignment of Benefits Rules - The OIG will investigate its belief that certain contractual arrangements involving reassignment of benefits among physicians and other entities raise compliance issues. The OIG specifically cited investigations in South Florida that allegedly revealed “schemes in which fraudulent providers obtain identifying information about legitimate physicians and request reassignments on their behalf.”

Other areas of interest to the OIG include Durable Medical Supplies, long-term care hospitals, home health agencies, skilled nursing facilities, Medicare Advantage programs, Part B Drug reimbursements, and Part D administration.

For more information or to view the 2008 OIG workplan in its entirety, please visit the following website:
http://oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf

EDITOR’S OPINION

Congress has thankfully delayed previously planned Medicare cuts, but the cuts planned for July 1st of this year have snowballed into a massive cut of 10.6% now and another 5% cut in January 2009. These decreases are due to the current Medicare Physician Payment Update Formula, which has kept current average reimbursement rates for Physicians at the level they were in 2001.

If the Medicare cuts are allowed, there will be an inevitable decrease in Medicare beneficiaries’ access to healthcare services. According to an AMA study, sixty percent of physicians will have to limit the amount of new Medicare patients they will accept or risk not being able to meet their payroll. This not only applies to Medicare beneficiaries, but will affect Tricare beneficiaries as well (as Tricare rates are tied to Medicare rates). These cuts could result in a potential crisis in healthcare access for seniors, disabled persons, and military members and their families.

With the July 1st date for implementation of Medicare cuts looming, now more than ever it is important for you to voice your concerns to your state’s legislators about the devastating impact this could have on most healthcare practices. These cuts could be the final straw in an already tenuous local health insurance reimbursement market. If this cut is allowed to go through, it will open the door not only to future Medicare decreases but will act as an opening for cuts in the rest of the carrier community as well. The trickle-down effect with the other major carriers could put many local practices out of business.

The Save Medicare Act of 2008 (Bill #S.2785) has been introduced in the Senate that would delay the scheduled Medicare cuts through the end of 2009, and allow some modest increases. As we are going to print, the bill is currently still “In Committee” with the Senate Committee on Finance.

NOW IS THE TIME TO ACT! MAKE YOUR VOICE HEARD THIS ELECTION YEAR! It is extremely important that you contact your local legislators and put them on notice as to how seriously this could impact not only the healthcare community, but also many people’s access to healthcare services. If members of Congress receive enough letters, emails, and faxes on this subject, it may speed up the passage of The Save Medicare Act.

If you need assistance with contacting your state’s legislators please visit the following websites:

- For the U.S. House of Representatives: <https://forms.house.gov/wyrl/welcome.shtml>
- For the U.S. Congress: http://www.senate.gov/general/contact_information/senators_cfm.cfm

• MGMA has a form letter available for you to use in writing to your Senators and Representatives, you can find it at the following link: <http://www.congressweb.com/cweb4/index.cfm?orgcode=mgma&hotissue=13>

NATIONAL UPDATES

MEDICAID

Written Prescriptions

On April 1, 2008, CMS implemented a policy stating that all written prescriptions must be on paper with at least one tamper-resistant feature as outlined by CMS (see below). Further, starting October 1, 2008 written prescriptions must be on paper that meets the baseline requirements outlined by CMS below:

1. Paper must prevent all unauthorized copying of a complete or blank prescription form
2. Paper must prevent erasure or modification of information written on the script by the provider
3. Paper must prevent the use of counterfeit forms

Each state Medicaid agency is responsible for issuing guidelines on meeting these regulations and when they apply.

More information can be found at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/tamperapril1.pdf>

Interest Rates

Effective April 18, 2008, the new Interest Rate for **Medicare** overpayments and underpayments is 11.375%.

MEDICARE

Revised ABN

A revised ABN form (CMS-R-131) was implemented on March 3, 2008. The new form replaces the General Use ABN and the Lab ABN. This version may also be used in place of the Notice of Exclusion from Medicare Benefits or NEMB form. New features of the form include a mandatory field for estimated costs of the service in question, and a new option that beneficiaries can choose that will let them receive the service and pay for it out of pocket rather than having a claim submitted to Medicare. CMS is allowing physicians six months to make the transition to the revised form, making it mandatory by September 1, 2008. You can find the form and its instructions at <http://www.cms.hhs.gov/BNI/>.

Subsequent Hospital Visits and Discharge Management Services

CMS has updated its payment policy for these services effective April 7, 2008. The new policy states that subsequent hospital care visits (codes 99231-99233) are not separately payable in the global surgical period even when a bill is fragmented for a staged procedure. It also states that hospital discharge services (codes 99238 and 99239) are only payable when they are performed face-to-face with the patient by the attending physician on record. You can read the notice of this change in its entirety at <http://www.cms.hhs.gov/MLNMMattersArticles/downloads/MM5794.pdf>

Medicare Preventative Services

For an updated guide to preventative services offered by Medicare and how to bill for these services, please go to the following website: <http://www.cms.hhs.gov/MLNMMattersArticles/downloads/SE0752.pdf>

New AJL and Federal District Court Appeals Amount Requirements

Effective January 1, 2008, and being implemented on May 5, 2008 the AIC (amount in controversy) for Administrative Law Judge Hearings must be at least \$120 and \$1,130 for Federal District Court Appeals.

COMMERCIAL

Cigna buys Great-West

[Cigna](#) now owns Great-West Healthcare. First announced in late November, the deal closed April 1, 2008. Cigna paid \$1.5 billion in cash for the healthcare business of Great-West Healthcare. Great-West provides coverage to more than 4,000 employer groups and 1.9 million people in the United States.

TIP OF THE MONTH

Make sure your practice stays HIPAA compliant. The OIG is getting busier in this area. It is important to take care of the little things:

- Use business associate agreements
- Incorporate HIPAA acknowledgements into standard form of consent
- Incorporate designation of family members into consent

Post notice of privacy practices (and don't forget electronic notice).

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